DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[HCFA-1069-P]

RIN 0938-AJ55

Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital. This proposed rule would implement section 1886(j) of the Social Security Act (the Act), as added by section 4421 of the Balanced Budget Act of 1997 (Public Law 105-33) and as amended by section 125 of the Balanced Budget Refinement Act of 1999 (Public Law 106-113), which authorizes the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units. It also authorizes the Secretary to require rehabilitation hospitals and rehabilitation units to submit such data as the Secretary deems necessary to establish and administer the prospective payment system. The prospective payment system described in this proposed rule would replace the reasonable cost-based payment system

under which the rehabilitation hospitals and rehabilitation units are currently paid.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on **[60 days after the date of publication in the Federal Register]**.

ADDRESSES: Mail written comments (one original and three copies) to the following address **ONLY**:

Health Care Financing Administration,
Department of Health and Human Services,
Attention: HCFA-1069-P,
P.O. Box 8010,
Baltimore, MD 21244-8010.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 443-G,
Hubert H. Humphrey Building,
200 Independence Avenue, SW,
Washington, DC 20201; or

Room C5-14-03,
Central Building,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

Comments mailed to the delivery addresses may be delayed and could be considered late.

FOR FURTHER INFORMATION CONTACT:

Robert Kuhl, (410) 786-4597 (General information).

Pete Diaz, (410) 786-1235 (Requirements for completing the Minimum Data Set for Post Acute Care (MDS-PAC), and other MDS-PAC issues).

Jacqueline Gordon, (410) 786-4517 (Payment system, the case-mix classification methodology, transition payments, relative weights/case-mix index, update factors, transfer policies, payment adjustments).

Nora Hoban, (410) 786-0675 (Calculation of the payment rates, relative weights/case-mix index, wage index, payment adjustments).

SUPPLEMENTARY INFORMATION:

Comments, Procedures, Availability of Copies, and Electronic Access

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA-1069-P.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443-G of the Department's office at 200 Independence

Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (Phone: (202) 690-7890).

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To assist readers in referencing sections contained in this document, we are providing the following table of contents.

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In addition, because of the many terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

ADL-Activities of Daily Living
BBA-Balanced Budget Act of 1997, Public Law 105-33
BBRA-Balanced Budget Refinement Act of 1999, Public Law 106-113
CMGs-case-mix groups
CMI-case-mix index
COS-Clinical Outcomes Systems
DRGs-diagnosis-related groups

FIM-functional independence measure
FIM-FRG-functional independence measurement-function related group
FRG-Function Related Group
FY-Federal fiscal year
HCFA-Health Care Financing Administration
HHAs-home health agencies
HMO-health maintenance organization
IRF-inpatient rehabilitation facilities
MDCN-Medicare Data Collection Network
MDS-PAC-Minimum Data Set for Post Acute Care
MedPAC-Medicare Payment Advisory Commission
MEDPAR-Medicare provider analysis and review
MPACT-MDS-PAC Tool - Minimum Data Set for Post Acute Care Tool
OASIS-Outcome and Assessment Information Set
ProPAC-Prospective Payment Assessment Commission
RICs-Rehabilitation Impairment Categories
SNF-skilled nursing facility
TEFRA-Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248
UDSmr-Uniform Data Set for medical rehabilitation
Y2K-Year 2000/Millennium

I. Background

When the Medicare statute was originally enacted in 1965, Medicare payment for hospital inpatient services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. The statute was later amended by section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) to limit payment by placing a limit on allowable costs per discharge. Section 601 of the Social Security Amendments of 1983 (Public Law 98-21) added a new section 1886(d) to the Social Security Act (the Act) which replaced the reasonable cost-based payment system for most hospital inpatient services.

Section 1886(d) of the Act provides for a prospective payment system for the operating costs of hospital inpatient stays effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although most hospital inpatient services became subject to a prospective payment system, certain specialty hospitals were excluded from that system. As discussed in detail in section I.A.1 of this preamble, rehabilitation hospitals and distinct part rehabilitation units in hospitals were among the excluded facilities. Subsequent to the implementation of the hospital inpatient prospective payment system, both the number of excluded rehabilitation facilities, particularly distinct part units, and Medicare payments to these facilities grew rapidly. In order to control escalating costs, the Congress, through enactment of section 4421 of the Balanced Budget Act of 1997 (BBA) (Public Law 105-33) and section 125 of the Balanced Budget Refinement Act of 1999 (BBRA)(Public Law 106-113), provided for the implementation of a prospective payment system for inpatient rehabilitation facilities.

Section 4421 of the BBA amended the Act by adding section 1886(j), which authorizes the implementation of a prospective payment system for inpatient rehabilitation services. This proposed rule would implement a Medicare

prospective payment system, as authorized by section 1886(j) of the Act, for inpatient rehabilitation hospitals and units. We refer to these inpatient rehabilitation hospitals and units as "inpatient rehabilitation facilities" or "IRFs" throughout this proposed rule.

The statute provides for the prospective payment system for IRFs to be implemented for cost reporting periods beginning on or after October 1, 2000. The statute also provides for a new prospective payment system for home health services for cost reporting periods beginning on or after October 1, 2000, along with modifications to the existing prospective payment systems for acute care hospitals and skilled nursing facilities.

Although we are working very hard to implement the extensive changes required by the statute, the demands of simultaneously implementing new prospective payment systems (for example, outpatient hospital and home health) and modifying existing payment systems are significant. The creation of each new payment system or modification to an existing payment system requires an extraordinary amount of lead time to develop and implement the necessary changes to our existing computerized claims processing systems. In addition, it requires additional time after implementation to ensure that these complex changes are properly

administered. After an extensive analysis of the changes required to HCFA's systems, we have concluded that it is infeasible to implement the IRF prospective payment system as of October 1, 2000. Therefore, we plan to implement the IRF prospective payment system for cost reporting periods beginning on or after April 1, 2001. We believe that this implementation date is the earliest feasible date given the scope and magnitude of the implementation requirements associated with this and other mandated provisions.

In this proposed rule, we provide a number of discussions useful in understanding the development and implementation of the IRF prospective payment system. These discussions include the following:

C An overview of the current payment system for IRFs.

C A discussion of research on IRF patient classification systems and prospective payment systems, including prior and current research performed by the RAND Corporation.

C A discussion of statutory requirements for developing and implementing an IRF prospective payment system.

C A discussion of the proposed requirement that IRFs complete the Minimum Data Set for Post Acute Care (MDS-PAC) (a patient assessment instrument) as a part of the data

collection deemed necessary by the Secretary to implement and administer the IRF prospective payment system.

C A discussion of the IRF patient classification system using case-mix groups (CMGs).

C A detailed discussion of the proposed prospective payment system including the relative weights and payment rates for each CMG, adjustments to the payment system, additional payments, and budget neutrality requirements mandated by section 1886(j).

C An analysis of the impact of the IRF prospective payment system on the Federal budget and inpatient rehabilitation facilities, including small rural facilities.

Finally, we are proposing conforming changes to existing regulations as well as new regulations that are necessary to implement the proposed IRF prospective payment system.

A. Overview of Current Payment System for Inpatient Rehabilitation Facilities

1. Exclusion of Certain Facilities from the Hospital Inpatient Prospective Payment System

Although payment for operating costs of most hospital inpatient services became subject to a prospective payment system when the hospital inpatient prospective payment system was implemented in October 1983, certain types of

specialty hospitals and units were excluded from that payment system. As set forth in section 1886(d)(1)(B) of the Act, the following hospitals were originally excluded from the hospital inpatient prospective payment system: psychiatric, rehabilitation, children's, and long-term care. Effective with cost reporting periods beginning on or after October 1, 1989 cancer hospitals were added to this list by section 6004(a) of the Omnibus Budget Reconciliation Act of 1989 Public Law (101-239). In addition, psychiatric and rehabilitation distinct part units of hospitals are excluded from the hospital inpatient prospective payment system.

These specialty hospitals were excluded by the Congress from the hospital inpatient prospective payment system because they typically treat cases that involve lengths of stay that are, on average, longer or more costly than would be predicted by the diagnosis related group (DRG) system and, therefore, could be systematically underpaid if the DRG system was applied to them. These exclusions were the result of concerns that DRGs--the classification system on which payment under the hospital inpatient prospective payment system is based--might not accurately account for the resource costs for the types of patients treated in those facilities.

The concern that DRGs might not accurately account for

costs in excluded hospitals arose because the hospital inpatient prospective payment system was developed from the cost and utilization experience of general hospitals, which typically provide acute care for a variety of medical conditions. The hospital inpatient prospective payment system is a system of average-based payments that assume that some patient stays will consume more resources than the typical stay, while others will demand fewer resources.

Thus, an efficiently operated hospital should be able to deliver care to its Medicare patients for an overall cost that is at or below the amount paid under the hospital inpatient prospective payment system. In a Report to Congress: Hospital Prospective Payment for Medicare (1982), the Department of Health and Human Services stated that the "467 DRGs were not designed to account for these types of treatment" found in the four special classes of hospitals, and noted that "including these hospitals will result in criticism. . . (and) their application to these hospitals would be inaccurate and unfair."

Accordingly, this report to the Congress suggested that a DRG system might not work as well for these treatment classes as they did for other medical specialties. One concern was that the resource needs of patients in these excluded hospitals were not solely correlated with

diagnoses. A second concern was that the mix of service intensities provided by these specialty hospitals significantly differed from that of general medical/surgical hospitals. The legislative history of the 1983 amendments to the Act stated that the "DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays." (Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany HR 1900, H.R. Rep. No. 98-25, at 141 (1983)).

Following enactment in April 1983 of the Social Security Amendments of 1983, we undertook a number of initiatives to ensure implementation of the hospital inpatient prospective payment system by October 1, 1983. Important activities included the publication of the rules and regulations for the hospital inpatient prospective payment system. The interim final rule was published in the September 1, 1983 **Federal Register** (48 FR 39752). We published a final rule in the January 3, 1984, **Federal Register** (49 FR 234) following a public comment period, evaluation of comments received, and formulation of responses to and regulatory revisions to the regulations based upon the comments. Updates and modifications of the

regulations are published annually in the **Federal Register**. Together, the initial statutory mandate and the published regulations addressed several important program issues. One program issue was the implementation of the criteria for hospitals that are seeking to be excluded from the hospital inpatient prospective payment system under one of the specialty classes, including IRFs. The regulations concerning exclusion from the hospital inpatient prospective payment system, in part 412, subpart B, are discussed below.

2. Requirements for Inpatient Rehabilitation Facilities to be Excluded from the Hospital Inpatient Prospective Payment System.

Under section 1886(d)(1)(B) of the Act, the prospective payment system for hospital inpatient operating costs set forth in section 1886(d) of the Act does not apply to several specified types of entities, including a rehabilitation hospital "as defined by the Secretary" or, "in accordance with regulations of the Secretary," a rehabilitation unit of a hospital which is a distinct part of the hospital "as defined by the Secretary." In general, existing regulations in part 412, subpart B provide that to be excluded from the hospital inpatient prospective payment system, an IRF must-- (1) have a provider agreement or be a unit in an institution that has in effect an agreement to

participate as a hospital under part 489; and (2) except for newly participating hospitals seeking to be excluded, demonstrate that they serve an inpatient population of whom at least 75 percent require intensive rehabilitative services for the treatment of 1 or more of 10 specified conditions. The specified conditions are stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, polyarthritis including rheumatoid arthritis, neurological disorders, and burns. Patients in IRFs require frequent physician involvement, rehabilitation nursing, and care from a coordinated group of professionals. (All IRFs that meet the requirements in §§ 412.23(b), 412.25, and 412.29 would be paid under the IRF prospective payment system proposed in this rule.)

3. Payment System Requirements Prior to the Balanced Budget Act of 1997

Hospitals that are excluded from the hospital inpatient prospective payment system are paid for inpatient operating costs under the provisions of section 1886(b) of the Act. Until the IRF prospective payment system is implemented, IRFs are paid on the basis of Medicare reasonable costs limited by a facility-specific target amount per discharge. Each facility has a separate payment limit or target amount

that is calculated for that facility based on its cost per discharge in a base year, subject to caps. The target amount is adjusted annually by an update factor called the rate-of-increase percentage. Facilities whose costs are below their target amounts receive bonus payments equal to the lesser of half of the difference between costs and the target amount, up to a maximum of 5 percent of the target amount. For facilities whose costs exceed their target amounts, Medicare provides relief payments equal to half of the amount by which the hospitals costs exceeded the target amount up to 10 percent of the target amount. Facilities that experience a more significant increase in patient acuity can also apply for an additional amount under the regulations for Medicare exception payments.

4. Strengths and Weaknesses of the Current Payment System

Utilization of post-acute care services has grown rapidly in recent years. Since the implementation of the hospital inpatient prospective payment system, average length of stay in acute care hospitals has decreased and patients are increasingly being discharged to post-acute care settings such as IRFs, skilled nursing facilities (SNFs), home health agencies (HHAs), and long-term care hospitals to complete their course of treatment. The increased utilization of post-acute care providers,

including excluded facilities, has fueled the rapid growth in payments in recent years. With increased utilization and the incentives associated with the reasonable-cost based payment system, discussed below, the number of IRFs has also increased significantly.

In its March 1999 Report to the Congress the Medicare Payment Advisory Commission (MedPAC)(formerly the Prospective Payment Assessment Commission (ProPAC)) stated, "Aggregate spending has increased at a fairly rapid pace, reflecting increased patient volume rather than increased payments per discharge. Aggregate Medicare operating payments to rehabilitation facilities rose 18 percent annually between 1990 and 1996, from $1.9 billion to $4.3 billion. Since 1990, payments per discharge have risen less than the rate of inflation, reaching $10,500 in 1996."(p.90.) The MedPAC report explains that the--

> TEFRA system has remained in effect longer than expected partly because of difficulties in accounting for the variation in resource use across patients in exempted facilities. The unintended consequences of sustaining that system have included a steady growth in the number of prospective payment system-exempt facilities and a substantial payment inequity between older and newer facilities. In particular, the payment system encouraged new exempt facilities to maximize their costs in the base year to establish high cost limits. Once subject to its relatively high limit, a recent entrant could reduce its costs below its limit, resulting in reimbursement of its full costs....By contrast, facilities that existed before they became subject to TEFRA could not influence their cost limits. Given the relatively low limits of older facilities,

> they are more likely to incur costs above their limits and thus receive payments less than their costs.(p.72)

To address concerns such as the historical growth in payments and disparity in payments to existing and newly excluded hospitals and units, the BBA mandated several changes to the current payment system. These changes are outlined in section I.C.1 of this preamble. In addition, we and other organizations have conducted research since the inception of the hospital inpatient prospective payment system to determine if alternate prospective payment systems are feasible for these excluded hospitals.

B. Research for Alternate Prospective Payment Systems for Inpatient Rehabilitation Facilities Prior to the Balanced Budget Act of 1997

Below is a discussion of research projects and other analyses concerning prospective payment systems that are relevant to the development of the IRF prospective payment system that we are proposing to implement in this rule.

The methods and tasks that must be undertaken in order to develop an IRF prospective payment system include development of a patient classification system that accounts for differences in patient case mix. A patient classification system is developed by classifying patients into mutually exclusive groups based on similar clinical

characteristics and similar levels of resource use. A factor to weight differences in patient case mix can be developed by measuring the relative difference in resource intensity among the different groups. We are proposing to implement a payment system that uses case-mix groups and weighting factors that account for the intensity of services delivered to IRF Medicare patients.

1. Early Studies

In October 1984, as mentioned in the 1987 Report to the Congress: Developing a Prospective Payment System for Excluded Hospitals (1987), the Medical College of Wisconsin and the RAND Corporation (RAND) began a joint effort to investigate the feasibility of a prospective payment system for excluded hospitals including IRFs. The RAND Corporation is a nonprofit institution with extensive health care background in improving policy and decision making through research and analysis. This joint effort was under a HCFA cooperative agreement with the RAND Corporation. The Medical College of Wisconsin collected data from a survey of patient records that included standard discharge data, diagnostic condition, functional status and other impairment measures, billing data, and facility information gathered from telephone interviews. RAND assisted in the design and analysis of the survey data and obtained a 20 percent sample

of the HCFA patient billing file for FY 1984--the implementation year of the hospital inpatient prospective payment system.

The data were used to analyze the delivery systems of rehabilitation care. The Report to the Congress stated that care in IRFs “emphasizes the treatment of functional limitations and disability”. Functional limitations could be measured by the patient’s ability to perform activities of daily living such as locomotion, dressing, eating, bathing, etc. The patient’s level of performing these activities of daily living is referred to as the patient’s functional status. The results of this analysis showed that “diagnostic condition explained little, whereas functional status measures explained substantially more, of the variance in total charges for a rehabilitation stay.” However, at the time of this analysis, a nationally-accepted set of functional status measures had not been developed for application in a classification system for IRFs.

2. Functional Status Studies

While numerous studies involved developing and assessing functional status, several researchers (for example, Batavia 1988; Johnston 1984) suggested using functional status as the basis for a rehabilitation payment system. Functional status, as measured by a patient's

ability to perform activities of daily living and by mobility, can be evaluated at admission and discharge or any time during the stay. In addition, change in functional status (the difference in functional status from admission to discharge) can be measured.

Researchers evaluated several methods of using functional status at different stages of the patient's stay to develop a payment system. For the most part, the use of these methods resulted in payment systems that appeared to be inadequate in creating the proper incentives to care for high resource use patients and to produce quality outcomes. Basing a payment system on expected improvement in a patient's functional limitations requires a scale that is sensitive to changes in functional status. In addition, precise data describing the functional status of the patient would have to be collected on admission and at periodic intervals until discharge (Hosek et al.; 1986).

The development of a patient classification system for a case-mix adjusted prospective payment system was hindered by the lack of an appropriate and widely accepted functional status measure for inpatient rehabilitation. The functional independence measure (FIM) was developed to fill this need (Hamilton et al., 1987). The functional independence measure addresses a patient’s functional status covering six

domains--self-care, sphincter control, mobility, locomotion, social cognition, and communication. There are two national sources of functional independence measures. The Uniform Data Set for Medical Rehabilitation (UDSmr) is operated within the Center for Functional Assessment Research, U. B. Foundation Activities, Inc. The UDSmr collects data on patient age, sex, living situation prior to hospitalization, the impairment that is the primary reason for admission to the IRF, and functional status at admission and discharge. It also includes patient admission and discharge information as well as hospital charges. The Clinical Outcomes System (COS) is operated by Caredata.com, Inc. (formerly Medirisk Inc.), located in Atlanta, Georgia. The COS contains the same type of patient information as UDSmr. However, we have been notified that the COS has been discontinued as of July 2000.

3. Studies on Patient Classification Systems

In 1991, Nancy Diane Harada presented a study in her dissertation titled "The Development of a Resource-Based Patient Classification Scheme for Rehabilitation." This study developed a clinically-based, diagnosis-specific patient classification system for rehabilitation hospital services. The final classification system in this study includes 33 patient classification groups. The patient

classification groups are referred to as Rehabilitation Functional Related Groups.

Harada believed that, at the facility level, the rehabilitation functional related groups could be viewed as a managerial tool to monitor the quality of care, as well as the resources expended in the treatment of rehabilitation patients. From a policy perspective, use of the rehabilitation functional related groups could minimize the adverse incentives for IRFs to underserve certain groups that may arise from the lack of case-mix index adjusted payments in the current cost limit payment system. The results of this study found that rehabilitation functional related group methodology may provide an appropriate basis for the prospective payment of rehabilitation services.

Using FIM data reported to UDSmr, a team of researchers from the University of Pennsylvania developed a patient classification system, Function Related Groups (FRGs), referred to as the FIM-FRGs (Stineman et al., 1994). The American Rehabilitation Association (currently known as the American Medical Rehabilitation Providers Association) funded the development of a prototype of function related groups. Further work and revisions were funded by the Agency for Health Care Research and Quality, formerly known as the Agency for Health Care Policy and Research and the

National Center for Medical Rehabilitation Research at the National Institutes of Health.

As FIM-FRGs were refined, they were reframed using the International Classification of Impairments, Disabilities and Handicaps to ensure a better measure of the consumption of rehabilitation resources, prognosis, and outcome (Stineman, 1997). These classifications were designed to be related to the major categories of the DRGs and indirectly linked to the ICD-9-CM with focus on disabilities and impairment categorization.

This original work on a FIM-FRG patient classification system identified 21 clinically defined rehabilitation impairment categories (RICs) such as stroke, traumatic brain dysfunction, non-traumatic brain dysfunction, and non-traumatic spinal cord injury. The RICs were then subdivided into FIM-FRGs using the FIM motor score, FIM cognitive score, and age. Accordingly, the FIM-FRG patient classification system first sorted patients into a RIC and then used assessments of patient functional and cognitive abilities and age to classify them into a FIM-FRG.

4. HCFA-Sponsored Analysis by RAND

In 1994, we contracted with RAND for analyses designed to: (1) examine the stability of the original FRGs; (2) extend the FRGs to take account of previously unexamined

cases (re-admissions), previously unused information (interrupted stays), and newly available data (Medicare data on comorbidities and complications); and (3) evaluate the performance of FRGs when cost rather than length of stay is used to form groups and when only Medicare cases rather than all cases are used to form groups.

RAND's analyses: (1) evaluated the suitability of the FIM-FRG patient classification system; (2) evaluated a prospective payment system for inpatient rehabilitation facilities based on the FIM-FRGs; and (3) prepared final reports describing the evaluation of the UDSmr, FIM, and FIM-FRGs. This analysis used more current data to replicate and update previous work performed by RAND in 1990.

Two data systems--the UDSmr and Medicare program information--were the primary sources for these analyses. UDSmr provided RAND with functional status and demographic information for rehabilitation discharge data on 139,360 cases from 352 IRFs from calendar year 1994. The Medicare program information included Medicare bill and cost report data for 1994.

The first step of the analysis involved matching UDSmr cases with Medicare records using patient and facility identifiers. Because patient and facility identifiers on the UDSmr records were encrypted, it was necessary to use a

sophisticated matching probability technique to match Medicare records to a corresponding UDSmr case. In addition, several thousand of the Medicare discharges corresponded to part of an interrupted rehabilitation stay. For the purposes of this analysis, a rehabilitation stay interrupted by a single admission to an acute care hospital is treated as two rehabilitation discharges, one interrupted by two admissions to an acute care hospital is treated as three rehabilitation discharges, and so on. Using this definition of "interrupted stays", RAND stated that the 139,360 cases found in the UDSmr data corresponded to 144,719 Medicare discharges. A file with the matched patient data was created.

RAND then subjected this patient data to a rigorous and complex statistical algorithm to test the predictive power of resource use to classify these patients into RICs and corresponding FIM-FRGs. As a result, RAND recommended that the number of FRGs per RIC be limited to a maximum of 5 and proposed a total of 70 FRGs. Facility level data from the hospital cost report information system file was used to test the feasibility of using the resulting FIM-FRGs to develop an IRF prospective payment system.

The results of the RAND study were released in September 1997 and are contained in two reports available

through the National Technical Information Service (NTIS). The reports are--

- Classification System for Inpatient Rehabilitation Patients-A Review and Proposed Revisions to the Function Independence Measure-Function Related Groups, NTIS order number PB98-105992INZ; and
- Prospective Payment System for Inpatient Rehabilitation, NTIS order number PB98-106024INZ.

These reports can be ordered by calling the NTIS sales desk at 1-800-553-6847 or by e-mail at orders@ntis.fedworld.gov.

RAND found that, with limitations, the FIM-FRGs were effective predictors of resource use based on the proxy measurement: length of stay. FRGs based upon FIM motor scores, cognitive scores, and age remained stable over time (prediction remained consistent between the 1990 and 1994 data). Researchers at RAND developed, examined, and evaluated a model payment system based upon FIM-FRG classifications that explains approximately 50 percent of patient costs and approximately 60 to 65 percent of costs at the facility level. Based on this analysis, RAND concluded that a rehabilitation prospective payment system using this model is feasible. RAND's design of a rehabilitation prospective payment system aimed to achieve the following three important goals:

- To provide hospitals with incentives for efficiency.
- To ensure access to high quality and appropriate care for all Medicare beneficiaries.
- To distribute Medicare payments to hospitals in an equitable way.

RAND needed to account adequately for each hospital's patient mix and for other appropriate factors that affect costs. This aspect of the analysis was based on the notion that Medicare should not pay hospitals more for inefficiency or even for a greater intensity of care than is typically received by patients with similar clinical characteristics and social support levels.

Two technical advisory panels provided advice concerning this research. The first panel reviewed the reliability of the FIM scoring process and the second panel provided guidance on the development of the patient classification system. These panels raised some major concerns about the FIM-FRG research.

First, the UDSmr data represented only 24 percent of IRFs and accounted for 40 percent of all Medicare cases in IRFs. Second, the UDSmr data over-represented free-standing rehabilitation hospitals and under-represented excluded units with a slight over-representation of teaching hospitals. Third, while the FIM-FRG system is a good

predictor of length of stay, more work was needed to determine the system's ability to predict the intensity of services furnished during a stay. Fourth, hospital charges might not accurately reflect actual resource use in this context, so relative weights based on hospital charges might be distorted. This problem would be further exacerbated because there is evidence of unexplainable distorted charging patterns among facilities under the current payment limits, which have been in effect for a prolonged period of time.

5. Prospective Payment Assessment Commission Analysis for 1997 Report to Congress

In its 1997 Report to Congress, the Prospective Payment Assessment Commission (ProPAC) recommended that a prospective payment system for IRFs based on patient case mix should be implemented as soon as possible. ProPAC stated that RAND's work on the FIM-FRGs could be an adequate basis for prospective payment, and that implementation of a system in the near future is feasible. (ProPAC's March 1, 1997 report was published as Appendix F to our proposed rule "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates" published in the June 2, 1997 **Federal Register** (62 FR 29902).)

In response to this recommendation, we cited in our final rule "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates" published in the August 29, 1997, **Federal Register** (62 FR 45966), the concerns raised by the technical advisory panels and our review of the RAND analysis as issues that needed to be further addressed before implementing a prospective payment system using the FIM-FRG patient classification system. In addition, we stated that our preference is to focus on developing a coordinated payment system for post-acute care across all settings that relies on a core assessment tool. Accordingly, one of our goals in developing a prospective payment system would be that it is based on the characteristics of the patient and their needs rather than the characteristics or type of provider of care.

C. Requirements of the BBA and the BBRA for Inpatient Rehabilitation Facilities

1. Provisions for the Current Payment System

The following BBA provisions relating to the current payment system were explained in detail and implemented in our final rule published in the August 29, 1997 **Federal Register** (62 FR 45966).

Section 4411 describes the update of payments for specific fiscal years (FYs) using the market basket

effective for cost reporting periods beginning on or after October 1, 1997.

Section 4412 describes the reduction of capital payments for FYs 1998 through 2002, effective October 1, 1997.

Section 4413 describes the provisions for rebasing a facility's target amount for cost reporting periods beginning during FY 1998.

Section 4414 describes the requirement to cap and update the rate-of-increase limits for cost reporting periods beginning on or after October 1, 1997.

Section 4415 describes the provisions regarding bonus and relief payments effective for cost reporting periods beginning on or after October 1, 1997.

Section 4419 eliminates the exemptions from the target amounts effective for cost reporting periods beginning on or after October 1, 1997.

2. Provisions for a Prospective Payment System

Section 4421(a) of the BBA amended the Act by adding a new section 1886(j) to the Act that provides for the implementation of a Medicare prospective payment system for all IRFs. For cost reporting periods beginning on or after the implementation date and before October 1, 2002, payment to IRFs will be based on a blend of--(1) the amount that

would have been paid under Part A with respect to these costs if the prospective payment system were not implemented and (2) the IRF Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, IRFs will be paid under the fully implemented Federal prospective payment system.

Under the prospective payment system, rehabilitation facilities will be paid based on predetermined amounts. These prospective payments will encompass the inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not for costs of approved educational activities, bad debts, and other costs not subject to the provisions of the IRF prospective payment system. Covered rehabilitation services include services for which benefits are provided under Part A (the hospital insurance program) of the Medicare program.

Section 1886(j)(1)(A) of the Act provides that, notwithstanding section 1814(b) of the Act and subject to the provisions of section 1813 of the Act regarding beneficiary deductibles and coinsurance responsibility, the amount of payment for inpatient rehabilitation hospital services equals an amount determined under section 1886(j) of the Act. Sections 1886(j)(1)(A)(i) and (ii) of the Act

provide for a transition phase covering cost reporting periods that begin during the first two Federal fiscal years under the prospective payment system. During this transition phase, IRFs will receive a payment rate comprised of a blend of the "TEFRA percentage" of the amount that would have been paid under Part A with respect to those costs if the prospective payment system had not been implemented, and the "prospective payment percentage" of payments using the IRF prospective payment system rate.

Section 1886(j)(1)(B) of the Act sets forth a requirement applicable to all facilities for the payment rates under the fully implemented system. Notwithstanding section 1814(b) of the Act and subject to the provisions of section 1813 of the Act regarding beneficiary deductibles and coinsurance responsibility, the amount of the payment with respect to the operating and capital costs of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, will be equal to the per unit payment rate established under this prospective payment system for the fiscal year in which the payment unit of service occurs.

Sections 1886(j)(1)(C)(i) and (ii) of the Act set forth the applicable TEFRA and prospective payment rate percentages during the transition period. For a cost

reporting period beginning on or after April 1, 2001 and before October 1, 2001, the "TEFRA percentage" is 66 2/3 percent and "the prospective payment percentage" is 33 1/3 percent; and on or after October 1, 2001, and before October 1, 2002, the "TEFRA percentage" is 33 1/3 percent and "prospective payment percentage" is 66 2/3 percent.

Section 1886(j)(1)(D) of the Act contains the definition of "payment unit." Until the passage of the BBRA, "payment unit" was defined by the statute as "a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary". However, section 125(a)(1) of the BBRA amended section 1886(j)(1)(D) of the Act by striking "day of inpatient hospital services, or other unit of payment defined by the Secretary." Accordingly, the payment unit utilized in the IRF prospective payment system will be a discharge.

Section 125(a)(3) of the BBRA also amended the Act by adding a new section 1886(j)(1)(E) to the Act that states: "(E) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.-Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care." We invite comments on the proposed transfer policy discussed in

section V. of this preamble.

Section 1886(j)(2)(A) of the Act, as added by the BBA, directed the Secretary to establish case-mix groups based on the factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient. This section also requires the Secretary to establish a method of classifying specific patients in rehabilitation facilities within these groups. The BBRA amended section 1886(j)(2)(A)(i) of the Act to describe the classification system to read as follows: "Classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a 'case mix group'), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups."

Section 1886(j)(2)(B) of the Act provides that the Secretary will assign each case-mix group a weighting factor reflecting the facility resources used for patients within the group as compared to patients classified within other groups.

Sections 1886(j)(2)(C)(i) of the Act directs the Secretary to adjust "from time to time" the case-mix

classifications and weighting factors "as appropriate to reflect changes in treatment patterns, technology, case-mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources." Such periodic adjustments shall be made in a manner so that changes in aggregate payments are a result of real changes in case-mix, not changes in coding that are unrelated to real changes in case-mix. Section 1886(j)(2)(C)(ii) of the Act provides that, if the Secretary determines that adjustments to the case-mix classifications or weighting factors resulted in (or are likely to result in) a change in aggregate payments that does not reflect real changes in case-mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of the coding or classification changes.

Section 1886(j)(2)(D) of the Act authorizes the Secretary to require rehabilitation facilities to submit such data as the Secretary deems necessary to establish and administer the IRF prospective payment system.

Section 1886(j)(3)(A) of the Act describes how the prospective payment rate will be determined. A prospective payment rate will be determined for each payment unit for which an IRF is entitled to payment under the prospective

payment system. The payment rate will be based on the average payment per payment unit for inpatient operating and capital costs of IRFs, using the most recently available data, and adjusted by the following factors:

- Updating the per-payment unit amount to the fiscal year involved by the applicable percentage increase (as defined by section 1886(b)(3)(B)(ii) of the Act) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor specified by the Secretary for subsequent fiscal years;
- Reducing the rate by a factor equaling the proportion of Medicare payments under the prospective payment system as estimated by the Secretary based on prospective payment amounts which are additional payments relating to outlier and related payments;
- Accounting for area wage variations among IRFs;
- Applying the case-mix weighting factors; and
- Adjusting for such other factors as determined necessary by the Secretary to properly reflect variations in necessary costs of treatment among IRFs.

Section 1886(j)(3)(B) of the Act directs the Secretary to establish IRF prospective payment system payment rates during fiscal years 2001 and 2002 at levels such that, in

the Secretary's estimation, total payments under the new system will equal 98 percent of the amount that would have been made for operating and capital costs in those years if the IRF prospective payment system had not been implemented. In establishing these payment amounts, the Secretary shall consider the effects of the prospective payment system on the total number of payment units from IRFs and other factors.

Section 1886(j)(3)(C) of the Act addresses the annual increase factor, to be applied beginning with FY 2001. This factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under section 1886(j) of the Act.

Under section 1886(j)(4)(A) of the Act, the Secretary is authorized but not required to provide for an additional payment to a rehabilitation facility for patients in a case-mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary. The amount of the additional payment must approximate the marginal cost of care above what otherwise would be paid and must be budget neutral. The total amount of the additional payments to IRFs under the prospective payment system for a fiscal year may not be projected to exceed 5 percent of the total

payments based on prospective payment rates for payment units in that year.

Section 1886(j)(4)(B) of the Act establishes that the Secretary is authorized but not required to provide for adjustments to the payment amounts under the prospective payment system as the Secretary deems appropriate to take into account the unique circumstances of IRFs located in Alaska and Hawaii.

Section 1886(j)(5) of the Act provides for the Secretary to publish in the **Federal Register**, on or before August 1 of each fiscal year, the classifications and weighting factors for the IRF case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

Section 1886(j)(6) of the Act provides that the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs that are attributable to wages and wage-related costs, of the prospective payment rates for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the IRF compared to the national average wage level for such facilities. Additionally, the Secretary is required to make a budget-neutral update to the area wage adjustment factor

no later than October 1, 2001, and at least once every 36 months thereafter. The budget neutral update is based on information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services.

Sections 1886(j)(7)(A), (B), (C) and (D) of the Act establish that there shall be no administrative or judicial review under sections 1869 and 1878 of the Act or otherwise of the establishment of case-mix groups, of the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments.

Section 125(b) of the BBRA provides that the Secretary shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the IRF prospective payment system. A report on the study must be submitted to the Congress not later than 3 years after the date the IRF prospective payment system is first implemented.

D. Policy Objectives in Developing a Prospective Payment System for Inpatient Rehabilitation Facilities

In developing the prospective payment system for IRFs, we identified policy objectives to evaluate the relative merits of the various policy options considered. The

objectives we identified include the following:

- The creation of a beneficiary-centered payment system that promotes quality of care, access to care, and continuity of care and is administratively feasible while controlling costs.
- The provision of incentives to furnish services as efficiently as possible without diminishing the quality of the care or limiting access to care.
- The creation of a payment system that is fair and equitable to facilities, beneficiaries, and the Medicare program.
- The IRF prospective payment system must be able to recognize legitimate cost differences among various settings furnishing the same service; and any patient classification system used to group patients and services should be based on clinically coherent categories and, at the same time, reflect similar resource use. This would limit opportunities to "upcode" or "game" the system.

In its March 1999 Report to the Congress, MedPAC recommended in detail the type of prospective payment system it believed should be implemented for IRFs. As will be discussed further in this proposed rule, MedPAC's recommendations share much with our approach and policy objectives for the development of an IRF prospective payment

system. Both HCFA and MedPAC believe the IRF prospective payment system should include the use of a comprehensive patient assessment instrument such as the MDS-PAC. HCFA and MedPAC both seek sufficient data to devise a patient classification system that effectively predicts resource use. HCFA and MedPAC believe the prospective payment system should be based on reliable and valid payment weights using functional and other diagnostic data. We agree with MedPAC's recommendation to use a per discharge unit of payment. Also, there is a shared belief that a discharge-based system provides an inherent incentive to discharge patients prematurely, and that this impetus could be overcome by implementing sound transfer and short-stay policies as part of the prospective payment system. Accordingly, we have taken steps to initiate the appropriate research to meet our immediate needs in developing this proposed rule and in implementing an IRF prospective payment system, as well as to collect data for the future that may reflect actual facility resources used to meet the needs of Medicare beneficiaries.

E. Discussion of Evaluated Options for the Prospective Payment System for Inpatient Rehabilitation Facilities

We used the objectives identified above in section I.D. of the preamble to evaluate policy options under

consideration. The IRF prospective payment system we are proposing consists of the following major components: the patient assessment instrument; the patient classification system; the unit of payment; and the data used to construct the payment rates. A brief discussion of the major issues and options considered in preparing this proposed rule follows.

1. Patient Assessment Instrument

Data from a patient assessment instrument will allow us to: (1) group patients into a CMG for payment under the prospective payment system; and (2) monitor the effects the prospective payment system has on the access and the quality of patient care. We have reviewed the data elements of the UDSmr and COS instruments and the MDS-PAC. We are proposing to use the MDS-PAC because we believe it contains the data elements that will better enable us to implement and administer the IRF prospective payment system required by section 1886(j) of the Act. In section III of this preamble, we will discuss in detail the reasons for our proposal to use the MDS-PAC patient assessment instrument.

2. Patient Classification System

The patient classification system is another important component of the prospective payment system. We initially considered two primary patient classification systems -- one

similar to the hospital inpatient prospective payment system and the other similar to the one used in the skilled nursing facility prospective payment system. Ideally, we would like to maintain similar classification systems for those entities delivering comparable services. We recognize a unified classification system would have to recognize patient needs and facilitate appropriate compensation across various post-acute care settings. Section 125(a) of the BBRA mandated the use of a per discharge payment unit and established classes of patients by functional-related groups. Therefore, in implementing the IRF prospective payment system we will use CMGs, consistent with section 1886(j)(2) of the Act.

3. Unit of Payment

Under the provisions of section 1886(j)(1)(D) as added by the BBA, we considered using either a per diem or a per discharge unit of payment. The vast majority of rehabilitation episodes begin with an acute event. The goal of inpatient rehabilitation is functional improvement that will allow the patient to return to independent living in the community, and, as evidenced by ongoing research, the majority of cases are, in fact, discharged to a community setting. Further, a discharge is also the current unit of payment under the TEFRA payment system. Finally, as noted

above, the BBRA amends the Act to provide that the "payment unit" under the IRF prospective payment system is the discharge. Therefore, we propose to use a per discharge payment unit in accordance with section 1886(j)(1)(D) of the Act.

4. Data Used to Construct Payment Rates

We gave careful consideration in deciding which data to use to create the proposed relative weights and payment rates. Two sources of data were considered: (1) Medicare bill and corresponding UDSmr/COS data; and (2) patient level staff time measurements. The methodology we are proposing to use to calculate the relative weights of each CMG attempts to account for the cost variations among rehabilitation facilities and focus on variations among patient types. Further, the payment rates we are proposing are established in a budget neutral manner in accordance with section 1886(j)(3)(B) of the Act. Section V of the preamble describes the methodology that we are proposing to use to develop relative weights and payment rates.

Under the current payment system, payment limits are based on historical costs in a base period. Accordingly, payments to a given facility for a given year might not accurately reflect the facility's actual costs in that year. Creating a new payment system based on costs that are a

product of the existing payment methodology raises concerns that these costs may not adequately reflect actual resource use. In order to develop a prospective payment system that is more reflective of the actual costs of delivering care, further work is needed to identify these costs and the services and resources required by patients. The IRF data from calendar years 1996 and 1997 bills and FY 1997 cost reports contain the most recent available data we have to create the new IRF prospective payment system rates.

We will continue to explore other options, including the use of staff time measurements, later Medicare bill and UDSmr/COS data, and other data to improve the explanatory power of the CMGs and to derive payments that more directly reflect the resources used to produce services delivered in the IRFs.

F. Inpatient Rehabilitation Facility Prospective Payment System - General Overview

In accordance with the requirements of section 1886(j) of the Act, we are proposing to implement a prospective payment system for IRFs that will replace the current reasonable cost-based payment system. The new prospective payment system will utilize information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected

resource needs. Separate payments are calculated for each group with additional case and facility level adjustments applied, as described below.

1. Patient Assessment Provisions

We are proposing to require IRFs to complete the MDS-PAC patient assessment instrument for all Medicare patients admitted or discharged on or after April 1, 2001. In accordance with our proposed assessment schedule, the MDS-PAC would be completed on the 4th, 11th, 30th, and 60th day from the admission date of a Medicare patient and upon the discharge of a Medicare patient. In general, a 3-day observation period would be required prior to the completion of the MDS-PAC. Data from the MDS-PAC will be used to --

C Determine the appropriate classification of a Medicare patient into a CMG for payment under the prospective payment system (using data from only the MDS-PAC completed on the fourth day);

C Implement a system to monitor the quality of care furnished to Medicare patients; and

C Ensure that appropriate case-mix and other adjustments can be made to the proposed patient classification system.

A computerized MDS-PAC data collection system will be developed. Facilities will be required to input the MDS-PAC data into the data system. In general, this system consists

of a computerized patient grouping software program (grouper software) and data transmission software.

Upon the discharge of the patient, the existing Medicare claim form will be completed with the appropriate CMG indicated on the claim form so that the prospective payment can be made. The operational aspects and instructions for completing and submitting Medicare claims under the IRF prospective payment system will be addressed in a Medicare Program Memorandum once the final system requirements are developed and implemented.

Further details about the MDS-PAC patient assessment instrument and data collection system are discussed in section III of this preamble.

2. Patient Classification Provisions

We are proposing a patient classification system that uses case-mix groups called CMGs. The CMGs classify patient discharges by functional-related groups based on a patient's impairment, age, comorbidities, and functional capability. We began the development of the CMGs by using the FIM-FRG classification system and, with the most recent data available, we identified clinical aspects of the FIM-FRG system that could be improved to increase the ability of the CMGs to predict resource use. Further details of the proposed CMG classification system are discussed in section

IV of this preamble.

3. Payment Rate Provisions

The payment unit for the proposed IRF prospective payment system for Medicare patients will be a discharge. The payment rates will encompass inpatient operating and capital costs of furnishing covered inpatient rehabilitation hospital services, including routine, ancillary, and capital costs, but not the costs of bad debts or of approved educational activities.

Beneficiaries may be charged only for deductibles, coinsurance amounts, and non-covered services (for example, telephone, and television, etc.). They may not be charged for the differences between the hospital's cost of providing covered care and the proposed Medicare prospective payment amount.

The prospective payment rates that we are proposing to implement are determined using relative weights to account for the variation in resource needs among CMGs. We would adjust the payment rates to account for area differences in hospital wages. We would update the per discharge payment amounts annually. During FYs 2001 and 2002, the prospective payment system will be "budget neutral", in accordance with the statute. That is, total payments for IRFs during these fiscal years will be projected to equal 98 percent of the

amount of payments that would have been paid for operating and capital costs of IRFs had this new payment system not been enacted. This is discussed in detail in section V of this preamble.

Based on our analysis of the data, we are proposing to adjust the payment rates for facilities located in rural areas and for costs associated with treating low income patients.

We are proposing to make additional payments to IRFs for discharges meeting specified criteria as "outliers." For the purposes of this proposed rule, outliers are cases that have unusually high costs when compared to the cases classified in the same CMG. We are proposing outlier payments that are projected to equal 3 percent of total estimated payments.

In conjunction with an outlier policy, we are proposing payment policies regarding short stay cases and for cases that expire. In addition, we are proposing to implement a transfer policy, consistent with section 1886(j)(1)(E) of the Act, as added by the BBRA. (A detailed description of these policies appears in section V of the preamble.)

4. Implementation of the Prospective Payment System

The statute provides for a 2-year transition period. During that time, 2 payment percentages will be used to

determine an IRF's total payment under the prospective payment system as follows. For a cost reporting period beginning on or after April 1, 2001 and before October 1, 2001, the total prospective payment will consist of 66 2/3 percent of the amount based on the current payment system and 33 1/3 percent of the proposed Federal prospective payment. For a cost reporting period beginning during FY 2002, the total prospective payment will consist of 33 1/3 percent of the amount based on the current payment system and 66 2/3 percent of the proposed Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, Medicare payment for IRFs will be determined entirely under the proposed Federal prospective payment methodology.

G. Applicability of the Inpatient Rehabilitation Facility Prospective Payment System

This proposed rule would not change the criteria for a hospital or hospital unit to be classified as a rehabilitation hospital or a rehabilitation unit that is excluded from the hospital prospective payment systems under sections 1886(d) and 1886(g) of the Act, nor would it revise the survey and certification procedures applicable to entities seeking this classification. Accordingly, for cost reporting periods beginning on or after April 1, 2001,

hospitals or hospital units that are classified as rehabilitation hospitals or rehabilitation units under subpart B of part 412 of the regulations will be paid under the proposed IRF prospective payment system (except for IRFs that are paid under the special payment provisions at § 412.22(c) of the regulations) as described below.

The following rehabilitation hospitals and rehabilitation units, that are currently paid under section 1886(b) of the Act, would be paid under the proposed IRF prospective payment system for cost reporting periods beginning on or after April 1, 2001:

1. Excluded Rehabilitation Hospitals and Rehabilitation Units

We are proposing that the IRF prospective payment system apply to inpatient rehabilitation services furnished by Medicare participating entities that are classified rehabilitation hospitals or rehabilitation units under §§ 412.22, 412.23, 412.25, 412.29 and 412.30.

2. Excluded Rehabilitation Hospitals and Rehabilitation Units outside the 50 States and the District of Columbia

Excluded rehabilitation hospitals and rehabilitation units located in Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Marianas, and the District of Columbia will be subject to the IRF prospective payment

system.

The following hospitals are paid under special payment provisions, as described in § 412.22(c), and, therefore, are not subject to the proposed IRF prospective payment system rules:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)).